STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	01/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from January 23, 2018 through January 30, 2018. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 79 . The investigated sample size was 27. NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; NP - Nurse Practitioner; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; SW - Social Worker; POA - Power of Attorney QA - Quality Assurance Administrator UM - Unit Manager; CNA flow sheet - a form that details care to be provided for each specific resident assigned; Email - electronic communication by computer; EHR - Electronic Health Record; EMR - electronic medication record; eMar - electronic medication administration record; heel boots - soft cushioned device that relieve the heel of pressure by suspending it in space; IPCP-infection prevention and control program; MDS - Minimum Data Set; standardized assessment forms used in nursing homes; Pressure ulcer (PU) - sore area of skin that develops when blood supply to it is cut off due to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 pressure; PRN - as needed; POA-power of attorney; Stage II (2) - blister or shallow open sore with red/pink color; w/c - wheel chair.	F 000		
F 602	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of facility policy, it was determined that the facility failed to ensure that one(R72)out of 27 sampled residents was free from misappropriation of resident property. Findings include: The facility policy titled Missing/Lost Property, approved on 6/12/2013 stated "When an item is reported missing staff will notify the nursing supervisor...An incident report will be initiated...and protocol followed." Review of a Care Conference Note, dated 8/8/17 revealed (name of POA) is concerned about items missing from the room and it is still going on. A blanket is the latest that is missing. Also a wind chime is missing. Thursday past, a church organization made a blanket and it has disappeared...Social Worker will continue to	F 602	On January 30, 2018 during an unannounced annual survey, surveyors found through interviews, record review, and policy review that the facility had not followed its policy regarding reporting and investigating missing resident property. Follow up revealed that R 72□s family had reported two missing items at a care conference on 8/8/17. The facility did not generate an incident report per policy. The facility recognizes that all events of misappropriation must be reported, recorded, and investigated, with the resident/POA notified of the outcomes. All residents have the potential to experience misappropriation of property, therefore all residents have the potential to be affected by this deficient practice.	4/30/18

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F 602	Continued From page 2 monitor as needed." During an interview with R72's family member on 1/24/18 at 1:22 PM, it was revealed that R72 was missing an Air Force blanket, and a Mother's Day ornament. R72's family member stated the items had not been found or replaced. During an interview on 1/25/18 at 11:24 AM, E5 (QA) stated that if a missing item was reported to the nurse and the nurse couldn't find it, an incident report would be filed. On 1/25/18 at 12:56 PM, E5 revealed there were no incident reports for any missing items for R72. During an interview on 1/30/18 at 11:51 AM, E10 (SW) stated that when something is reported missing the UM would initiate an incident report. During an interview on 1/30/18 at 12:39 PM, E11(UM) stated that R72's family member did not report the missing items until a few months later, at a care plan meeting. E11 stated staff did look for the items, but the items were not found, and an Incident Report was not filed. Findings were reviewed with E1(NHA), E2(DON), and E3(ADON) at the exit conference on 1/30/18 at approximately 3:30 pm.	F 602	The facility will review its current policy for missing resident property and update the policy to clearly direct staff on reporting guidelines and follow through for resolution. A standardized spreadsheet will be used by Social Services to track the investigation, notification, and potential replacement (when deemed appropriate) of missing items. Staff will receive training with the policy and any revisions to ensure employees understand the process and its importance. Social Services will receive additional training related to completing the spreadsheet for tracking. The policy review and revision will be initiated immediately with training to start no later than March 1, 2018. The process will be implemented on April 1 with 75% of staff having completed training. Staff Development will collect documentation of completed training and forward a list to Quality Assurance. A monthly audit will be conducted by social services to reconcile any reports of missing items with a correlating Incident Report, as well as updated tracking on the standardized spreadsheet. Upon three successful months of 95% correlation/completion, reconciliation will be added to the QA Plan for Social Services to report on quarterly.	
F 686	Severity/Scope = 2/1 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		5/15/18

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F 686	Continued From page 3 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to provide treatment and services to promote healing of a pressure ulcer (PU) for one (R228) out of 27 sampled residents. Findings include: Review of R228's clinical record revealed the following: 1/3/18 - A new onset stage 2 PU to R228's right heel was documented in the clinical record. 1/19/18 - A physicians order was written for R228 to have no shoes on and heel boots at all times until right heel, is healed . 1/30/18 - At 8:23 AM R228 was observed being transported to dining room for breakfast in w/c wearing socks and slippers. 1/30/18 - At 9:36 AM R228 was observed in the day room in a recliner wearing the same socks and slippers.	F 686	On January 30, 2018 during an unannounced annual survey, surveyor observations found that a resident with a right heel pressure ulcer was not wearing a heel boot at all times according to the physician order. The resident instead was observed wearing slippers for an extended period while out-of-bed. Through staff interviews it was determined that the order was not implemented due to lack of initial and sustained communication between and among nursing staff. The facility acknowledges that nursing staff caring for the resident should have known the resident□s status regarding her wearing the heel boot. When brought to the attention of the Unit Manager, immediate steps were taken to clarify the order with the physician to ensure the resident was wearing appropriate foot-ware when out-of-bed. Additionally, the CNA flow-sheet and nursing care plan were updated to reflect	

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F 686	Continued From page 4 1/30/18 - At 9:40 AM, following a dressing change observation completed by E7 (LPN), under E7's direction, E9 (CNA) put socks and slippers back on R228's feet. During an interview on 1/30/18 at 9:53 AM with E8 (CNA) who was assigned to care for R228, it was reported that R228 only wears boots in bed and when out of bed was to have no shoes. E8 then provided the surveyor with a current copy of the CNA flow sheet which documented R228 to have heel boots on when in bed. During an interview on 1/30/18 at 9:55 AM with E7, R228's current physician's orders were reviewed with the surveyor and E7 confirmed that R228 should be wearing heel boots at all times. During an interview on 1/30/18 at 9:56 AM with E6 (RN) Unit manager it was confirmed that R228 was to be wearing heel boots at all times. E6 stated "I didn't see that order, to update the CNA flow sheet, and then update the staff to ensure everyone is aware." An order was written for heel boots at all times on 1/19/18 and on 1/30/18 R228 was observed without heel boots. During an interview, it was reported that direct care staff was unaware of the order; supervisory staff confirmed a failure to update CNA flow sheets and staff to ensure everyone was aware of the changes. These findings were reviewed on 1/30/18 at approximately 3:30 PM with E1 (NHA), E2 (DON) and E3 (ADON) during exit conference.	F 686	and communicate the order clarification. All residents have the potential to be affected by the same deficient practice. The resident□s pressure ulcer did not progress or worsen. Measures put in place to ensure that this deficient practice does not recur include close monitoring and enforcement to ensure that resident orders and information are communicated during shift-to-shift rounds and verbal report, as well as through completion of the 24-hour Chart Check and updating of the CNA Flowsheet and resident care plan. An audit tool was developed to track the performance of shift-to-shift rounds and verbal report as well as the completion of the 24-chart check. This audit will be completed daily by each Unit Manager. The House Nursing Supervisor will complete care plan audits for each unit weekly. The resulting data will be communicated to the Unit Manager to address with staff. A roster of all Nursing staff trained on completing shift-to-shift rounds and verbal report and the 24-hour chart check, as well as updating the CNA Flowsheet and nursing care plan will be maintained by Staff Development. Infractions found during the House Nursing Supervisor and/or Unit Manager Audits will be addressed. Using an audit tool, monitoring and enforcement of the performance of shift-to-shift rounds and verbal report,	

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F 686	Continued From page 5	F 686	completion of 24-hour chart checks, and updating of the CNA flow-sheet and resident care plan is anticipated to improve incrementally by 25% over the next three months to achieve a baseline target completion rate of 75%. Thereafter, monitoring and enforcement will be ongoing with a goal threshold 85%.	
F 790	Severity/Scope = 2/1 Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident;	F 790		4/30/18

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F 790	Continued From page 6 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on review of the EHR and resident and staff interviews it was determined that the facility failed to ensure that transportation to and from a dental appointment was arranged for one (R33) out of 27 sampled residents. Findings include: Review of R33's EHR revealed the following: 12/8/17 2:55 PM - A nurse's progress stated that R33 has an oral surgery appointment for removal of a left upper back tooth scheduled for 1/2/18. 12/8/17 3:40 PM - A physician's progress note stated that R33 has an oral surgery appointment for removal of a tooth on 1/2/18. 1/2/18 - Review of physician and nursing progress notes lacked mention of R33's dental appointment. 1/23/18 10:40 AM - During a resident interview, R33 stated the facility never transported him for the dental appointment scheduled on 1/2/18. 1/26/18 10:42 AM - During a second interview,	F 790	On January 30, 2018 during an unannounced annual survey, surveyor interviews and reviews of the electronic medical record found that one resident was not transported to a scheduled dental appointment due to the missed appointment information not being relayed to the Appointment Scheduler. The facility acknowledges that it bears the responsibility of arranging transportation for dental appointments. After awareness the facility rescheduled the resident□s dental appointment and the resident was placed on the transport calendar. All residents who are scheduled to attend dental appointments have the potential to be affected by the same deficient practice. Measures put in place to ensure that this deficient practice does not recur include establishing a process for not only recording all medical referrals for outside clinic appointments, which include dental appointments scheduled by the facility,	

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F 790	Continued From page 7 R33 stated that the facility has not provided any information regarding the missed dental appointment on 1/2/18. 1/26/18 11:30 AM - In an interview, E10 (SW) stated that she was not aware that R33 had missed a dental appointment on 1/2/18 and that she would look into it. 1/26/18 2:10 PM - During an interview, E10 stated she found that the order for R33's 1/2/18 dental appointment did not get forwarded to E12 (transportation scheduler). As a result, there was no transport arranged for R33 and the 1/2/18 appointment was missed. E10 stated that E12 was not at work today but she would speak with her on Monday about rescheduling the appointment. 1/30/18 approximately 11:30 AM - In an interview E10 stated that E12 has been trying to reschedule the dental appointment since 1/3/18 with no success. The facility failed to arrange transportation for R33's dental appointment on 1/2/18 resulting in a missed appointment. These findings were reviewed on 1/30/18 at approximately 3:30 PM with E1 (NHA), E2 (DON) and E3 (ADON) during exit conference.	F 790	but also their disposition□that is whether the resident attended the appointment and if the resident did not attend the appointment, indicating why not so that transportation can be rescheduled. Hence, a log in a spreadsheet format has been developed for use by the Appointment Scheduler to document the aforementioned items. Additionally, as a back-up measure, a new protocol will be implemented that requires the driver(s) who transports residents to dental and other clinic appointments outside the facility to report to the transportation supervisor whether residents listed on their roster for transport to a scheduled dental appointment were transported. If a resident was not transported to an a scheduled dental appointment, the transportation supervisor will notify, via email, a group of facility staff that includes medical team members, Unit Manager, Unit Social Worker and Nursing Supervisor. The Unit Manager, and in that person□s absence, the Nursing Supervisor, will investigate to determine why the resident was not transported to the missed dental appointment and relay that information to the medical team, Unit Social Worker, and Appointment Scheduler. The medical team member will order a new dental appointment referral. Once received the Appointment Scheduler will schedule a new dental appointment and notify the transportation supervisor. The Appointment Scheduler will audit the scheduling log weekly to track the number	

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F 790	Continued From page 8	F 790	of residents who were and who were not transported to scheduled dental and other clinic appointments outside the facility. Reasons why a transport did not occur particularly for scheduled dental appointments will be noted in the log. The goal of this weekly audit over a period of two months is to ensure 100% of residents with scheduled dental appointments are transported to attend them. Those residents who are identified and reported during the audit to have not been transported to a dental appointment will have their appointments rescheduled within one week of the missed appointment 100% of the time.	
F 880	Severity/Scope = 2/1 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		5/31/18

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F 880	Continued From page 9 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 10 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation and interview it was determined that the facility failed to establish an infection control program that included ongoing analysis of surveillance data, review of surveillance data, and documentation of follow up activity in response to collected surveillance data. The facility failed to implement surveillance of the practices of staff directly related to resident care in order to identify whether staff implemented and complied with the facilities infection control program policies and procedures. The facility failed to administer medications in a manner to prevent the spread of infection for one (R44) out of 28 sampled residents. Findings include: 1. Review of facility documentation revealed the following: July 2017-January 2018 - Review of the facility's infection control documentation lacked evidence that the facility was analyzing, reviewing, and documenting any follow up activity in response to collected surveillance data. 1/24/18 1:35 PM - During an interview with E3 (ADON), it was confirmed that the facility did not analyze, review, or conduct any follow up in response to the collected infection surveillance data. E3 stated, that when there were trends staff	F 880	On January 30, 2018 during an unannounced annual survey, surveyor observations, interviews and reviews of documentation found the following: 1) The residents and staff did not receive the benefit of an established facility infection control program that included an ongoing review and analysis of infections occurring within the facility and of staff infection control practices. The lack of infection and infection control surveillance data and a documented follow up response to the data collected impacted the facility□s ability to control the spread of infections among its residents, staff, and visitors. The facility recognizes the need to have a surveillance component in its infection control program. Upon awareness the Infection Control and Prevention Coordinator immediately developed a policy that provides a framework within the Infection Control Program whereby surveillance via data collection and reporting and education are addressed. 2. The surveyors also determined through review of infection control program documentation that there was no evidence indicating that staff care practices complied with facility infection	

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F 880	Continued From page 11 discussed it, but did not analyze or review the data. E3 stated that the only information the facility was documenting regarding infections was line listings of current infections and antibiotic usage. E3 stated that the facility was working on their infection control program, and they had not realized the new regulations were currently in effect. These findings were reviewed on 1/30/18 at approximately 3:30 PM with E1 (NHA), E2 (DON) and E3 (ADON) during exit conference. 2. Review of facility documentation revealed the following: July 2017-January 2018 - Review of the facility's infection control documentation lacked evidence that the facility observed and reviewed the practices by staff that directly related to resident care. The facility documentation did not show that the facility determined whether staff implemented and complied with the facility ' s Infection Control Program policies and procedures. 1/26/18 1:23 PM - During an interview with E3 (ADON), it was confirmed that the facility's Infection Control Program did not include surveillance of staff practices that directly related to resident care. E3 stated that the facility does not currently include surveillance of staff, but the facility will be adding it to their program. E3 stated that the facility was working on their infection control program, and they had not realized the new regulations were currently in effect. These findings were reviewed on 1/30/18 at approximately 3:30 PM with E1 (NHA), E2 (DON)	F 880	control policies. The facility recognizes the need to observe, review and document staff care practices to minimize the spread of infections. The IC Coordinator reviewed the existing Infection Control Policy to ensure it outlined staff procedures and practices in containing potential infections and has developed a plan to monitor and document staff compliance. 3) Finally, the surveyors, observed a nurse administer an ophthalmic medication in a resident□s unaffected eye and then wipe both eyes using the same tissue. The facility recognizes that this act was not within nurse practice standards and had the potential to spread infection to the resident□s unaffected eye. Nursing Administration has identified the involved nurse so that education and remediation can occur with the nurse. All residents have the potential to be affected by the same deficient practices. Measures put in place to ensure that the above-mentioned deficient practices do not recur include the following: 1) Development and implementation of a Monthly Infection Control Report Summary that will be completed by the third day of each month and will be presented at the quarterly Infection Control Committee meeting. In that meeting, reviews of facility infections occurring during the month and comparisons of that data to the previous month and year, will serve as a basis for	

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	085051	A. BUILDING _____ B. WING _____	01/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963

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F 880	Continued From page 12 and E3 (ADON) during exit conference. 3. Medication Administration 1/23/18 (10:15 AM - 10:40 AM) - During observation of R44's medication administration E13 (LPN) administered two different eye drops, one drop in each eye. With the first eye medication, the nurse started with the right eye, which recently had an infection, and used a tissue to wipe excess. After administration of the medication in the left eye the same tissue was used, increasing the chance of spreading contaminants from the right eye to the unaffected eye. When administering the second eye medication E13, again, started with the right eye and used a new tissue to wipe the eye. The nurse proceeded to the left eye and used the same tissue to wipe that eye. During an interview with E13 on 1/23/18 around 10:50 AM the nurse confirmed the same tissue was used to wipe both eyes after each eye medication. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at exit conference on 1/30/18 around 3:30 PM.	F 880	committee members to implement a targeted response to control the spread of infections. Trends and concerns will be reviewed with the facility staff to heighten awareness of current infections and educate on preventing the spread. 2) Staff care practices related to infection prevention will be audited monthly by the Nursing Leadership Team, according a calendar developed by the ICP Coordinator. 3) Education and remediation of the involved nurse will ensue. Additionally, administering eye medications will become an annual clinical competency monitored by Staff Development through return demonstration. The Infection Control quarterly meeting minutes will document discussion and review of the Monthly Infection Control Report Summary. Additionally, an audit tool will be developed for the purpose of monitoring care practices demonstrated accurately by staff during monthly audits. Any audited care practice with less than 80% compliance will result in the ICP providing a standard of practice review on the topic as remediation. A follow up audit will occur to ensure 85% compliance. Finally, the annual competency for ophthalmic administration with return demonstration will be implemented in May 2018 and demonstrate 85% compliance.	
F 881	Severity/Scope = 2/3 Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		3/31/18

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F 881	Continued From page 13 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview it was determined that the facility failed to establish an antibiotic stewardship program that included education for staff and residents about antibiotic stewardship. Findings include: Review of facility documentation revealed the following: 12/27/17-12/29/17 Review of the Introduction to Antibiotic Stewardship education sign in sheet showed that only 12 staff members were in attendance. 1/30/18 1:53 PM - During an interview with E3 (ADON), it was confirmed that the facility did not educate all staff and residents about antibiotic stewardship. E3 stated that none of the residents have been educated and only a "handful" of staff have been educated on the antibiotic stewardship program. E3 (ADON) stated that the facility was under the impression that the antibiotic stewardship regulations were delayed until 2019, therefore, they had not currently completed all the requirements. These findings were reviewed on 1/30/18 at	F 881	On January 30, 2018 during an unannounced annual survey, surveyor reviews of documentation found that the facility did not have an established Antibiotic Stewardship Program that educated staff and residents about Antibiotic Stewardship. After awareness, the Infection Control and Prevention Coordinator (ICPC) had developed an Antibiotic Stewardship policy and had initiated staff education about this program. All residents have the potential to be affected by the same deficient practice. Measures put in place to ensure that this deficient practice does not recur include implementing the following: 1. Existing digital signage has been updated to include additional information about the process to reduce infections related to antibiotic misuse. 2. The ICP Coordinator is meeting with staff from all departments to provide education about Antibiotic Stewardship. Sign in sheets will be maintained by the	

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F 881	Continued From page 14 approximately 3:30 PM with E1 (NHA), E2 (DON) and E3 (ADON) during exit conference. Severity/Scope = 2/3	F 881	ICP Coordinator; copies will be sent to Staff Development for their files. 3. The ICP Coordinator will provide basic Antibiotic Stewardship information to attendees in New Employee Orientation. 4. The ICP Coordinator will hold educational sessions with residents who have a BIMS score of 11 or greater and will introduce AS in the February 2018 Resident Council. 5. The ICP will provide this education to the resident families via a letter sent out by Social Services staff. The ICPC will audit Antibiotic Stewardship meeting sign-in sheets to ensure 85% of the staff and 85% of residents with BIMS scores at 11 or greater have attended the meeting within 30 days. Also, the numbers of mailings sent to resident families with an AS flier will be reported by Social Services and reviewed monthly by the ICPC until 100% is achieved.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: January 30, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from January 23, 2018 through January 30, 2018. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 79 (seventy-nine). The investigated sample of residents totaled 27.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.2.0	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed January 30, 2018: F602, F686, F790, F880 and F881.	Cross refer to CMS 2567-L survey completed January 1, 2018: F602, F686,F790,F880 and F881.	

Provider's Signature William Peterson Title DIRECTOR Date 3/2/18